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Vestibular History Form

Patient Name: ________________________ Date:____________________

Do you experience dizziness/imbalance? Yes No

Describe how your dizziness/imbalance problem feels: ______________________________

When did your dizziness/imbalance start? (date)
Was there any related event? Yes No

Date of your most recent dizzy spell?

Was the onset of your dizziness/imbalance: Sudden or Gradual

Is your dizziness/imbalance: Constant or Comes and goes in spells

How often does your dizziness occur?

How long does your dizziness last?

Are you completely dizzy-free between spells? Yes No

Is there anything that makes your dizziness better? Yes No
If yes, please explain

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Is there anything that makes your dizziness worse? Yes No
If yes, please explain

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Does changing positions make you dizzy? Yes No

Have you ever fallen due to your dizziness/imbalance problem? Yes No

Do any of the following accompany your dizziness?

- Headache	Yes	No
- Nausea	Yes	No
- Vomiting	Yes	No
- Blackout or loss of consciousness	Yes	No
- A change in vision (double vision, blurred vision, etc)	Yes	No
- Numbness/weakness in face, arms, or legs	Yes	No

Do you have history of a cold or flu prior to your recent dizzy spell? Yes No

Have you ever had migraines? Yes No

Difficulty hearing? Yes No
If yes, which ear: Right Left Both

Fullness or pressure in your ears? Yes No
If yes, which ear: Right Left Both

Pain or discharge from your ears? Yes No
If yes, which ear: Right Left Both

Ringing in your ears? Yes No
If yes, which ear: Right Left Both

Do you have any of the following medical problems? (Please circle)

- Allergies
- Diabetes
- High blood pressure
- Motion sickness
- Stroke
- Head trauma
- Ear surgery
- Neck/back problem
- Knee/hip joint problem
- Thyroid problem

Please list all medications you currently take:

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